Statement
of the

American Medical Association

to the

Federal Trade Commission and Department of Justice
Hearings on Health Care Competition Law and Policy
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Physician IPAs: Patterns and Benefits of Integration, and Other Issues

September 25, 2003

The American Medical Association (AMA) is pleased to offer the perspective of practicing physicians on several topics raised by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) as they wrap up this year-long series of hearings on health care competition law and policy with physician-specific issues. We commend the Commission and the Department for holding these hearings which have presented a vital forum for all stakeholders in the health care system to flesh out and delve deeper into some of the complex issues facing health care markets. The timing is critical because the AMA believes the realities of the marketplace demand a serious re-examination of the agencies' enforcement priorities, as well as a change in enforcement policies regarding joint contracting by physician networks.

Just over a year ago, the process that lead to these hearings began with the September 2002 Workshop on Health Care Competition Law and Policy. At that Workshop, the AMA communicated two core messages. These messages, which have formed the foundation of our testimony presented this year, are as follows:

1. Physicians have been placed under a far higher level of scrutiny than is warranted by our comparative economic strength in today's health care system.

2. In contrast to the antitrust treatment of physicians, health insurers have amassed significant market power through a wave of mergers but have received minimal scrutiny by federal regulators.

Something is amiss. The AMA has presented substantial evidence in support of these propositions. We noted that the wave of consolidations in the health insurance industry has been followed by record profits and increased premiums. Yet, rather than focus on the health insurance industry, the response of regulators has been to "find and bring" cases against physicians. This is particularly perplexing in light of the fact that it is beyond dispute that physicians are not to blame for the rise in health care costs.

Ironically, as we have presented this testimony over the past year, events in the marketplace have only served to exacerbate further this troubling dynamic, and it is important to elucidate those developments for the record.

Developments on the Health Insurer Side

On the health insurer side, yet another wave of health plan mergers is gathering force. On October 27, 2003, WellPoint Health Networks, Inc., and Anthem, Inc., sent shock waves through health care markets with the announcement that Anthem was acquiring WellPoint to form the nation's largest insurer. This new insurer will provide coverage to over 26 million Americans. On the same day, United Health Care announced that it was acquiring MAMSI, which will bring the total number of commercial covered lives by United to 19 million. After the mergers, Anthem and United will control a quarter of all commercially insured lives.

Anthem and United Health Care are spending almost $19 billion to acquire Anthem and MAMSI so they can control a bigger piece of the health insurance pie. Further, it has been reported that WellPoint CEO Leonard Shaeffer stands to make $330 million from stock options on the Anthem acquisition, in addition to another $27.5 million under the terms of his contract.

These enormous expenditures come at a time when insurance premiums have risen by double digits for the past three years - and they continue to rise - adding to the number of uninsured. And who ultimately pays for the mergers? Patients, physicians and other health care providers. The financing for these purchases and excessive compensation packages will ultimately impinge upon patients - in the form of further premium increases and/or decreased services to patients.

Moreover, observers predict that the Anthem/WellPoint merger will have a domino effect as other health insurers seek merger/acquisition targets. The AMA is increasingly alarmed that the United States is headed toward a system dominated by a few publicly-traded companies that operate in the interest of shareholders, and not primarily in the interest of the ultimate consumer of healthcare—our patients.

Preliminary results of the AMA's 2003 study, Competition in Health Insurance: A Comprehensive Study of U.S. Market, also merit attention. We looked at 89 metropolitan areas this year, compared to 70 in 2002 and 40 in 2001. The study was based on 2001 data, the most current available. The preliminary results show that:

- In the combined HMO/PPO market, 92 percent (82) of the metropolitan areas are highly concentrated (HHI >1800) according to the 1997 FTC/DOJ Horizontal Merger Guidelines.

- In 92% of these metropolitan areas, there is at least one insurer with a combined HMO/PPO market share in excess of 50 percent. In a third of these metropolitan areas, there is at least one insurer with a combined HMO/PPO market share in excess of 70%.

- In the 27 less populated states (populations less than five million with no metropolitan area-level data), in the combined HMO/PPO market, 89% (24) are highly concentrated. In 93 percent (25) of these state-level markets, there is at least one insurer with a combined HMO/PPO market share in excess of 30%. In 63% of these state-level markets, there is at least one insurer with a combined HMO/PPO market share in excess of 40%, and in 41% (11) of these state level markets, there is at least one insurer that has a combined HMO/PPO market share in excess of 50 percent.

The combination of a new wave of unfettered mergers coupled with already high levels of concentration in markets around the country should concern lawmakers and regulators. It does not paint of picture of robust competition in health insurance markets.

Developments on the Physician Side

Ironically, in an environment where physicians around the country are faced with the overwhelming market power of health insurers, the FTC is devoting substantial resources to pursuing physicians for alleged violations of the antitrust laws. Since April 2002, the FTC has brought at least 16 cases against physician groups. All but two of the groups chose to settle with the FTC rather than engage in a protracted, financially devastating legal battle. A significant number of these cases involve alleged misuse of the "messenger model" by IPAs or other physician networks.

The result is a profound chilling effect on physicians pursuing innovative activities. It also provides stark evidence that the "messenger model" represents a false hope for physicians and that the 1996 DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care have not provided flexibility to adapt to a changing marketplace.

The foremost concern of the AMA has always been to safeguard the patient-physician relationship. We believe that disempowering physicians raises serious detrimental consequences to patients. Too often, when physicians attempt to join together to address legitimate concerns and to prompt the interests of their patients, the antitrust laws seem to get in the way. This is a serious problem in an increasingly monolithic health insurance market.

The AMA's Message

Against this backdrop, the AMA's message becomes vital. As we testified at the 2002 Workshop, it is time to take a fresh look at some of the core principles that have guided antitrust enforcement in the health care sector. In our view, some of these principles do

not hold up to close examination. They are simply assumptions which have never been proven and which, in our view, have outlived any purpose they once may have served. Instead of now revisiting each of these assumptions which we explained in great detail in previous testimony for the 2002 Workshop and in our oral statement for the hearing on the messenger model, we incorporate by reference (and resubmit for the record) our previous testimony on clinical integration and application of the "messenger model" to be considered in the context of this last set of hearings.

We will, however, reiterate our central message: When physicians create a network to market their services jointly to payers, the Rule of Reason rather than the *per se* rule should generally apply. The physician network should not be **required** to do risk contracting, to "clinically integrate," or to use the so-called "messenger model" in order to avoid charges of price-fixing. We believe that the Rule of Reason is capable of distinguishing between physician networks that are truly harmful to competition and those which offer procompetitive benefits such as greater flexibility and more innovation.

We do not propose that physician networks be free to engage in manifestly anticompetitive behavior. Quite to the contrary, outright boycotts or naked agreements on price (unrelated to the network's contracting activities) may continue to be treated as illegal *per se.* Our point is simply that, absent such egregious conduct, fee-for-service contracting should not be exposed to the heavy artillery of the *per se* rule.

Current enforcement policy assumes that physician joint contracting on a fee-for-service basis never offers any significant efficiencies. (We set aside for the moment the special case of "clinical integration"). We believe this assumption is mistaken.

If a hypothetical, non-exclusive physician network were permitted to propose a "package price" for the services of its members, we submit that joint contracting by such a network would offer transactional efficiencies that cannot, and should not, be easily dismissed. These transactional efficiencies are not merely the *de minimis* efficiencies offered by any cartel. Rather, they are efficiencies that can result in significant cost savings both for the payer and for the physicians.

For payers, physician joint contracting can make it possible to obtain ready access to a panel of physicians offering broad geographic and specialty coverage. Because physicians still practice predominantly in solo practice or in small groups, creating a physician panel can be a very time-consuming and expensive task for a payer seeking to enter or expand its place in a market. In its complaint in *United States v. Aetna*, the Justice Department noted that "effective new entry for an HMO or HMO/POS plan in Houston or Dallas typically takes two to three years and costs approximately $50,000,000."[1] When the initial task of network formation is undertaken by the physicians themselves, payers may substantially reduce the costs of entry and expansion.

[1] *United States v. Aetna*, No. 3-99CV1398-H (N.D. Tex.) (complaint filed June 21, 1999).

In this sense, the formation of a fee-for-service physician network can be viewed as a "new product" under the Supreme Court's decisions in *BMI*, *NCAA*, and *Maricopa*.[2]

For physicians, a network would enable them to pool their resources to afford the necessary expertise to evaluate contract proposals. Whereas payers have sophisticated actuarial and financial resources to enable them to evaluate contract proposals, physicians are often in the dark when they consider a contract. By pooling their resources, physicians may be able to individually negotiate from a more informed position– without restraining competition.

In other contexts, courts and antitrust agencies have recognized that transactional efficiencies may be sufficient to take conduct out of the *per se* category.[3] Why should physicians be treated differently? Ironically, while enforcement policy continues to dismiss any potential efficiency from fee-for-service networks, the market has generally shifted away from risk contracting.[4] The "flight from risk" has been attributed to many factors – significantly, the desire of many employers and individuals to do business with health plans that do not place physicians under financial incentives to withhold care.[5] Should antitrust policy really stand in the way of physicians participating in the market to respond to this consumer demand? Should our hypothetical physician network be prohibited from competing on an even keel with the national or regional PPO?

The Supreme Court's decision in *Maricopa* is sometimes viewed as creating a strict *per se* prohibition against fee-for-service contracting by a physician-sponsored network. But the decision need not, and should not, be read so broadly. First, *Maricopa* was a 4-3 decision that is in tension with other Supreme Court cases holding similar joint arrangements to be subject to the Rule of Reason.[6] Second, in *Maricopa* there was no factual record before the Court on the potential efficiencies of joint contracting; the

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[2] *Broadcast Music, Inc. v. CBS*, 441 U.S. 1 (1979) ("*BMI*"); *National Collegiate Athletic Association v. Board of Regents*, 468 U.S. 85 (1984) ("*NCAA*"); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982); *see also* F. Easterbrook, "Maximum Price Fixing," 48 U. Chi. L. Rev. 886, 898-99 (1981) (noting that transactional efficiencies of joint contracting may justify treating physician network as a 'new product' as in *BMI*); H. Hovenkamp, Federal Antitrust Policy: The Law of Competition and Its Practice § 5.6 (1994) (a non-exclusive physician network is "absolutely inconsistent with the economics of cartelization: no cartel could restrict its output and raise price if it permitted its members freely to come and go, or to make unlimited 'non-cartel' sales."); California Business and Professions Code section 16770 (health care provider contracting networks are "a new product within the healthcare marketplace…").

[3] *See generally* D. Balto, "Cooperating to Compete: Antitrust Analysis of Health Care Joint Ventures," 42 *St. Louis Univ. L.J.* 191, 223-25, & nn. 192-97 (1998) (citing cases and other authorities).

[4] *See* R. Hurley, J. Grossman, T. Lake, & L. Casalino, "A Longitudinal Perspective on Health Plan-Provider Risk Contracting," *Health Affairs* 144, 152 (July/August 2002).

[5] *Id.* at 144-45; *see* A. Hillman, "Financial Incentives for Physicians in HMOs – Is There A Conflict of Interest?" *New Eng. J. Med.* 1729-34 (Dec. 31, 1987).

[6] *See, e.g., BMI*, 441 U.S. 1 (1979); *NCAA*, 468 U.S. 85 (1984).

parties did not argue the point. Absent a developed record on efficiencies, the case should not be viewed as offering the final word on the subject. Finally, the Commission has already recognized that "clinical integration" offers sufficient prospect for efficiencies to take joint pricing outside *Maricopa*.

Once the potential efficiencies of joint contracting are recognized, the Rule of Reason provides the appropriate tool for balancing those efficiencies against the potential for harm to competition. Under the Rule of Reason, a variety of factors need to be considered. Professor Havighurst summarized some of the relevant considerations as follows:

- Did the physicians genuinely intend to offer a competitive alternative in the market?
- What percentage of physicians in the geographic market are participants in the venture?
- Do the participating physicians participate in networks that are not physician-controlled?
- How sophisticated and effective are purchasers of physician services in the relevant market?
- How vigorous is competition generally in the relevant market?[7]

Again, the AMA believes that the Rule of Reason is up to the task of distinguishing between physician networks that harm competition and those which offer procompetitive benefits such as greater flexibility, more innovation, and ultimately a better health care system.

Conclusion

Thank you for the opportunity to present our views. Again, we applaud the Commission and the Justice Department for holding these hearings to reexamine antitrust enforcement policies and competition in the health care industry. The AMA respectfully urges the agencies to take these recommendations very seriously. We look forward to a continuing dialogue with the agencies on these and other important issues.

[7] C. Havighurst, "Are the Antitrust Agencies Overregulating Physician Networks," 8 *Loyola Consumer L. Rptr*. 78, 88 (1996).